DEPARTMENT	OF HEALTH AN	ND HUMAN	SERVICES
CENTERS FOR	MEDICARE &	MEDICAID	SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155760		(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE COMPI 08/04/2	LETED	
	PROVIDER OR SUPPLIER	CROSSING HEALTH CAMPUS	· ·	1332 W	ADDRESS, CITY, STATE, ZIP CODE VATERFORD CIRCLE EN, IN46526	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0000	Complaint #IN00 Federal/State def allegation are cit. F354.  Survey Dates: 8/2 Facility number: Provider number Aim number: 200 Survey Team: E Census bed type: SNF: 18 SNF/NF: 40 Total: 58 Census payor type Medicare: 18 Medicaid: 16 Other: 24 Total: 58 Sample: 3 These deficiencies	0094000 - substantiated, ficiencies related to the ed at F157, F282 and  3-4/11  011150 : 155760 0831020  Ilen Ruppel, RN	F0	0000	This Plan of Correction constitutes the written alleg of compliance for the deficicited. However, submission this Plan of Correction is admission that a deficiency or that oe was cited correct. This Plan of Correction is submitted to meet the requirements established but not federal law. The Maples Waterford Crossing Health Campus desires this Plan of Correction to be considered facility's allegation of compliance is effective Aug 31, 2011. The Maples at Waterford Crossing Health Campus respectfully reque Plan of Correction be submas desk review for compliant the deficiencies cited.	encies n of ot an exists ly.  y state at of d the iance. gust	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

011150

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SU		
AND PLAN	OF CORRECTION	155760	A. BUILDING	00	COMPLET 08/04/201	
		100700	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/01/201	' '
NAME OF P	ROVIDER OR SUPPLIER		ı	VATERFORD CIRCLE		
MAPLES	AT WATERFORD C	CROSSING HEALTH CAMPUS	I	EN, IN46526		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE (	COMPLETION DATE
	Quality review co	ompleted 8/6/11	0			J.H.S
F0157 SS=D	A facility must immoresident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuconditions or clinical alter treatment significant change mental, or psychosocial statuconditions or clinical alter treatment significant in a condition or clinical alter treatment significant in a consequence of the cons	nediately inform the vith the resident's physician; y the resident's legal an interested family member occident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or is in either life threatening all complications); a need to inficantly (i.e., a need to sting form of treatment due uences, or to commence a nent); or a decision to ge the resident from the				
	resident and, if known representative or in when there is a ch	own, the resident's legal nterested family member ange in room or roommate				
	a change in reside	ecified in §483.15(e)(2); or int rights under Federal or ations as specified in				
	paragraph (b)(1) o	of this section.				
	update the address	ecord and periodically s and phone number of the presentative or interested				
		ews and record review,	F0157	It is the expectation of this fa	cility	08/31/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155760	B. WIN		<del></del>	08/04/2	011
		<u> </u>	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	8			ATERFORD CIRCLE		
MAPLES	AT WATERFORD	CROSSING HEALTH CAMPUS		1	EN, IN46526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	the facility failed	I to notify the cardiac			to immediatly inform the resid	dent;	
	transplant team of	of the admission of one of			consult with the resident physician; a significant change	no in	
	one transplant re	cipients in a sample of			the resident's physicial, ment	-	
	three to the facil:	ity. Resident C			and psychosocial status; nee		
	Findings include				alter treatment significantly; of decision to transfer or dischathe resident from the facility. I corrective action will be done	or a irge What	
	During the orien	tation tour, on 8/3/11 at			the facility?Resident C's	- ~ ,	
	8:40 a.m., LPN #	‡2 identified Resident C			cardiologist was notified of		
	as being a recent	admission and having			resident's admission to the		
	1	splant recipient in the			facility. A physicians order to		
	past. The reason				restart Prograf was received 7-19-2011. How will the facili		
	1 ^	ndicated by LPN #2 as			identify other residents havin	•	
		fractures of the left femur			potential to be effected by the		
	and right wrist.	ractares of the left femal			same practice and what		
	and right wrist.				corrective action will be taken		
	The clinical reco	ord for Resident C was			audit of resident charts has be completed and no other resident completed and no other resident audit of resident charts has be completed and no other resident audit of resident charts has be completed and no other resident audit of resident charts has be completed and no other resident audit of resident charts has be completed and no other resident audit of resident audit of resident audit of resident audit of resident audi		
					were found to be effected.WI		
		/11 at 10:00 a.m., and			measures will be put into pla		
		d been admitted to the			ensure this practice does not		
	<u> </u>	11. Admission orders			recur?The facility reviewed it		
	included an orde	er to notify the heart			policy and found it to be suffi		
	transplant medic	al group of the resident's			Licensed staff were re-educa	ited	
	admission to the	facility. One of the two			on physician's notification of change in condition. See ext	hibit	
	antirejection med	dications (Prograf) had			A and B.Addendum: Newly h		
	been stopped by	the orthopedic physician			licensed staff will complete		
		sion to the facility and the			Clinical Systems Monitoring		
	1	lcept) had been continued			Training as a part of their	e.	
	`	rders to the facility.			orientation program. Comple date: 8/31/2011How will	etion	
		indicate and indinity.			corrective action be monitore	ed to	
	Nurses notes da	ted 7/19/11 (no time			ensure the deficit practice do		
					not recur and what QA will be		
	1 * /	ted the resident had			into place?The Director of He	ealth	
		urse about not getting			Services, or designee, will		
		ejection medications for			audit new admissions within		
	two and one-half	f days. The note indicated			first seventy-two (72) hours to	0	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155760	B. WIN			08/04/2	011
		I	B. ((1)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8		1	ATERFORD CIRCLE		
MAPLES	AT WATERFORD	CROSSING HEALTH CAMPUS		1	EN, IN46526		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	when the nurse a	ttempted to contact the			ensure nursing tasks includir		
	heart transplant g	group, a voice mail was			orders and physician notifica		
	all she could acc	ess. The nurses note			has been completed. The DF will report the results of this a		
	indicated the voi	ce mail at the cardiac			to the Quality Assurance	auuit	
		e indicated the group was			committee for the next three	(3)	
	gone for two day				months and thereafter as	` ,	
	Some for two day	o at a sommat.			determined by the QA		
	The resident was	s sent to the local			committee. This will begin immediatly and will be		
		and the physician in the			ongoing.Addendum 8/23/201	1:	
	1 -	contacted the heart			These audits will continue for		
	1 -	cian. The hospital note			each admission until the		
		rere able to contact her			audits measure 100% compl		
	1				for 100% of the charts audite		
		n (city). He called the			for three (3) consecutive mor Completion date: 8/31/2011	itris.	
	nursing home an	_			Completion date: 0/31/2011		
	prescribed and sl	he will start getting that					
	hopefully today	or tomorrow."					
	Review of the M	ledication Administration					
	Record (MAR) f	For July 2011, on 8/3/11 at					
	10:30 a.m., indic	cated the Prograf had been					
	·	1/11. The resident had not					
		lication from the date of					
		ge on 7/16/11 until					
		ginal hospital orders did					
		Prograf was to be					
		id indicate the cardiac					
		was to be notified of the					
		sion to the long term					
	facility.						
	During an inters	iew with Resident C, on					
	_						
		m., she indicated she was					
		was first admitted to the					
	facility if she wa	s being given the Prograf					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CEZ711 Facility ID: 011150

If continuation sheet

Page 4 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		(X2) MULTIPLE A. BUILDING B. WING	O0	(X3) DATE SURVEY COMPLETED 08/04/2011	
	PROVIDER OR SUPPLIER	CROSSING HEALTH CAMPUS	1332	ET ADDRESS, CITY, STATE, ZIP CODE WATERFORD CIRCLE HEN, IN46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	recognize of if it She indicated wh been discontinue check with the tra when he was not emergency room it restarted. The had included an of transplant team.	which she did not had been discontinued. en she thought it had d she asked the nurse to ansplant physician and reached, she went to the to be checked and have original hospital orders order to notify the cardiac relates to Complaint			
F0282 SS=D	facility must be proin accordance with plan of care. Based on intervithe facility failed orders to notify the team of the admit transplant recipies to the facility. R Findings include During the orient		F0282	It is the expectation of the for that the services provided or arranged by the facility must provided by quality persons accordnce with each resider written plan of care. What corrective action will be done the facility? Resident C's cardiologist was notified of resident's admission to the facility. A physicians order to restart Prograf was received 7-19-2011. How will the facility other residents having	t be in ints e by o I on ity

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE :	) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155760	B. WIN			08/04/2	011
		II.	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8		1	ATERFORD CIRCLE		
MAPI ES	S AT WATERFORD	CROSSING HEALTH CAMPUS		1	EN, IN46526		
				L			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG	-	LSC IDENTIFYING INFORMATION)	+	IAG	potential to be effected by the		DATE
		t admission and having			same practice and what	E	
		splant recipient in the			corrective action will be taken	n?An	
	past. The reasor	for the current			audit of resident charts has b		
	admission was in	ndicated by LPN #2 as			completed and no other resid		
	being for recent	fractures of the left femur			were found to be effected.W		
	and right wrist.				measures will be put into pla		
					ensure this practice does not		
	The clinical reco	ord for Resident C was			recur?The facility reviewed it policy and found it to be suffi		
		1/11 at 10:00 a.m., and			Licensed staff were re-educa		
	1	d been admitted to the			on physician's notification of		
					change in condition and		
	-	11. Admission orders			guidelines for admission orde	ers.	
		er to notify the heart			See exhibit A, B, and		
	transplant medic	al group of the resident's			C.Addendum 8/23/2011: Nev	•	
	admission to the	facility. One of the two			hired licensed staff will comp	lete	
	antirejection me	dications (Prograf) had			Clinical Systems Monitoring Training as a part of their		
	been stopped by	the orthopedic physician			orientation program. Comple	etion	
	the day of admis	sion to the facility and the			date: 8/31/2011How will		
	<u> </u>	lcept) had been continued			corrective action be monitore	ed to	
	`	rders to the facility.			ensure the deficit practice do		
		racis to the facility.			not recur and what QA will be		
	No	4-4-7/10/11 ( +:			into place?The Director of He	eaith	
	1	ted 7/19/11 (no time			Services, or designee, will audit new admissions within	the	
	1 * '	ted the resident had			first seventy-two (72) hours t		
	1 *	urse about not getting			ensure nursing tasks includir		
		ejection medications for			orders and physician notifica		
	two and one-half	f days. The note indicated			has been completed. The DF		
	when the nurse a	attempted to contact the			will report the results of this a	audit	
	heart transplant	group, a voice mail was			to the Quality Assurance committee for the next three	(3)	
	1 * '	ess. The nurses note			months and thereafter as	(3)	
	indicated the voi	ce mail at the cardiac			determined by the QA		
		e indicated the group was			committee. This will begin		
	gone for two day				immediatly and will be ongoin	ng.	
	gone for two day	is at a sciiiiiai.			See exhibit DAddendum		
	The state				8/23/2011: These audits will	471	
		s sent to the local			continue for each admission	until	
	emergency room	and the physician in the			the audits measure 100%		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155760	A. BUI	LDING	00	COMPL 08/04/2	
		193760	B. WIN			06/04/2	011
NAME OF	PROVIDER OR SUPPLIEF	3		1	ATEREORD CIRCLE		
MAPLES	S AT WATERFORD	CROSSING HEALTH CAMPUS		1	ATERFORD CIRCLE :N, IN46526		
				L			are)
(X4) ID PREFIX	1	STATEMENT OF DEFICIENCIES  NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	emergency room	contacted the heart			compliant, for 100% of the cl	narts	
	1 0 1	cian. The hospital note			audited, for three (3) consec	utive	
	1 1 1	vere able to contact her			months. Completion date:		
	•	n (city). He called the			8/31/2011By what date the systemic changes will be		
	nursing home an	• • /			completed:August 31, 2011		
	1	he will start getting that					
	hopefully today						
	Review of the M	Iedication Administration					
	Record (MAR) f	for July 2011, on 8/3/11 at					
	10:30 a.m., indic	cated the Prograf had been					
	restarted on 7/20	0/11. The resident had not					
	received the med	dication from the date of					
	hospital discharge	ge on 7/16/11 until					
	7/20/11. The ori	iginal hospital orders did					
	not indicate the	Prograf was to be					
	continued, but d	id indicate the cardiac					
	transplant group	was to be notified of the					
	resident's admiss	sion to the long term					
	facility.						
	During an interv	riew with Resident C, on					
	1	m., she indicated she was					
	unsure when she	e was first admitted to the					
	1	as being given the Prograf					
	in a generic forn	n which she did not					
	I -	had been discontinued.					
		hen she thought it had					
	1	ed she asked the nurse to					
	1	ransplant physician and					
	1	t reached, she went to the					
	1	to be checked and have					
		original hospital orders					
	had included an	order to notify the cardiac					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPL			ETED	
		155760	B. WING			08/04/2	011
NAME OF F	DOLUBED OF GUIDNIE			_	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1332 W	ATERFORD CIRCLE		
MAPLES	AT WATERFORD	CROSSING HEALTH CAMPUS		GOSHE	N, IN46526		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
IAG	transplant team.	ESC IDENTIF LING INFORMATION)	+	IAG	,		DAIL
	transpiant team.						
	This federal tag I	relates to Complaint					
	3.1-35(g)(2)						
F0354 SS=A	(d) of this section, services of a regis	ed under paragraph (c) or the facility must use the tered nurse for at least 8 a day, 7 days a week.					
	(d) of this section,	ed under paragraph (c) or the facility must designate to serve as the director of me basis.					
	nurse only when to daily occupancy of Based on time shall interviews, the far Registered Nurse	rsing may serve as a charge the facility has an average of 60 or fewer residents. The et print outs and acility failed to have a te on the premises for a 24 the day of the three like.	F0.	F0354  It is the expectation of this fat to have Registered Nurse services for a minimum of at eight (8) consecutive hours a seven (7) days a week. What corrective action will be done the facility? The facility has hif four (4) Registered Nurses services date of survey. These Regist Nurses will be scheduled on		least a day, e by	08/31/2011
	Findings include	:				ince tered	
	(DON), on 8/4/1 indicated there we in the facility from a.m., on 7/18-7/1	d Director of Nursing 1 at 12:00 noon, both vas no Registered Nurse m 6:00 a.m., to 6:00			shifts and will be working full status. How will the facility ide other residents having the potential to be effected by the same practice and what corrective action will be taken? The facility reviewed it policy for staffing and Registe Nurse coverage and found it	time entify e t's ered	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		155760	B. WIN			08/04/2	011
NAME OF I	DOMED OF CHIRD IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1332 W	ATERFORD CIRCLE		
		CROSSING HEALTH CAMPUS		GOSHE	EN, IN46526		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility during th	e 24 hour period, but had			sufficient. An audit of license	d	
	been called away	on a family emergency			staffing through August 31, 2011 has been completed ar	d no	
	and had not been	able to come to the			other concerns have been	ia no	
	facility. She indi	icated other Registered			idenitifed. What measures w	ill be	
	· ·	er facilities had been "on			put into place to ensure this		
		tually in the facility. She			practice does not recur?The		
		•			schedule of nursing shifts wi		
		ility had been staffed with			reviewed by the Director of H	lealth	
		al Nurses (LPNS) on all			Care Services and the		
	halls during the p	period.			Community Clinical Manager		
					minimum of three (3) times p		
	Review of the tir	ne print out sheet for the			week to assure coverage of scheduled shifts to remain in		
	DON, on 8/4/11	at 10:00 a.m., the			compliance with both state a		
	f f	cated she was not in the			federal guidelines. Any	<del></del>	
	facility on 7/18-1				opportunities will be covered		
	14011111 011 //10-1	. // 11.			immediatly. This staffing will		
	T1.1 C. 1 14	-1-44- C1 : 4			reviewed in the morning mee	-	
	_	relates to Complaint			How will corrective action be		
	IN00094000.				monitored to ensure the defi-		
					practice does not recur and v QA will be put into place?Thi		
	3.1-17(b)(3)				staffing will be reviewed in		
					morning meeting and quarte	rly at	
					QA to assure compliance. Bo		
					the Executive Director and the		
					Human Resource Director w	ill be	
					present to evaluate the number		
					staff needed to hire to assure		
					adequate staff to meet the no	eeds	
					of the facility. This will begin	oa Du	
					immediatly and will be ongoi what date the systemic chan		
					will be completed:August 31,		
					2011		